INSTRUCTIONS – INDIVIDUAL SERVICE PLAN – MEDICAID WAIVERS

No.	Title	Description
1	Waiver Program	The Waiver program in which person is enrolled. Check only one of the Medicaid Waivers listed in the field.
1a	Plan Type	**"New"** refers to persons who are first enrolling in the waiver; **"Annual Recertification"** refers to a new plan updated by at least having new signatures and submitted to comply with waiver recertification requirements; **"Update"** means the plan replaces an earlier plan and shows some form of change such as in the type of services to be received by the participant or that there has been a change in provider. **"CLTS Crisis**" refers to plans associated with crisis slots only in CLTS waivers. "**CLTS Pilot**" applies only to the CLTS Waiver.
2	Medicaid ID Number	Enter the 10 digit Medicaid number assigned to the person listed on the plan.
3	Individual's Name	Enter his/her full legal last name, first name, middle initial and suffix (e.g., Jr.)
4	Address (street)	The place where the waiver applicant/participant resides.
4a	City, State	
4b	Zip code	Use 5 digit code
5	Mailing address (if different)	The address the person receives personal mail if different from where they reside.
6	Telephone	The area code and telephone number at the place the person resides.
7	E- Mail	The e-mail address of the participant. If the person does not have an e-mail, another e-mail address that can be used to transmit e-mail messages.
8	Service Plan Development Date	The date on which the service planning process was initiated and the initial service plan was accepted by all parties involved in its development. **Note:** This is the earliest date on which waiver services may begin.
9	Functional Screen Date	Enter the Long Term Care Functional Screen completion date.
10	Cost Share Amount	The amount of money the waiver participant must contribute to the cost of **waiver-covered** services each month. The amount is based on the DDE -919 Form or CARES. Excludes parental fee (See Field No. 12).
11	Level of Care	The level of care as determined by the long term care functional screen (Adult or Children's LTC-FS) or the approved BIW level of care.
12	Parental fee (if applicable)	The amount parents are required to contribute to the overall cost of waiver covered services for their dependant child. Applies to all Waivers that serve children.
13	Personal Discretionary Funds	The amount of the individual's personal funds available to the individual for use to pay for non-waiver personal discretionary items and services such as recreational activities. The use of these funds is determined by the waiver participant and/or authorized by their guardian, if any and not by the county or the provider. These funds may be managed by a third party rather than by the county or the waiver service provider. This amount is what remains after the participant pays for the actual cost of their room and board at their residence.
14	Reserved for Future Use	
15	Start Up/One Time Costs Total	The use of this field changes with the time period to which the plan applies. **START UP COSTS** When the waiver participant starts on the waiver, field 15 in the person's **initial** individualized service plan is to be used for "start up" costs. At this point in time, these may include one time costs for items needed for the person to live in the community or for services necessary to plan and implement plans that occur prior to the point the person starts on the waiver. Such services must be covered by the waiver but delivered, not more than 90 days or 180 days, depending on the applicable waiver, (See waiver manual, Chapter IV for details.) prior to the person's waiver plan development date.

No.	Title	Description
		Start up costs must be included in the person's **initial** individual service plan during an episode of services to be eligible for reimbursement and may not be included in subsequent plans during the current episode of services. The **initial** plan is defined as the plan that takes effect on the "service plan development date" of an episode of services. Start up costs listed in the participant's initial plan are limited to waiver covered services necessary for the person to start community services and live in the community. Include all start up costs in field 15 including costs incurred under any services such as housing start up, support and service coordination and any of the services that involve the purchase of items such as home modifications and adaptive aids. Also includes costs for initial consultations/evaluations needed from various experts such as behavior specialists, occupational/physical therapists, etc. when the person first moves from an institution and the cost of approved specialized training. **ONE-TIME COSTS** In all plans after the first plan, field 15 must be used for one-time costs only. One-time costs are defined as costs incurred after the initial plan that pay for items or services that are anticipated to be purchased on a one time or time-limited basis and which are not anticipated to continue or recur. One-time costs are typically items used as adaptive aids, home modifications done after a services have been provided or for time limited consultations needed to respond to a transitory situation that, when resolved, will not need to be addressed with the subject services. Do not include one-time costs for items such as adaptive equipment here if the item is covered or is expected to be covered by the Medicaid card (state plan). Items or services covered by Medicaid or other non-waiver sources (e.g., COP) need be specified in the plan using fields 63-69 for each such one time item or service. The recurring cost of maintaining equipment purchased and used as an adaptive aid cited should be considered to be ongoing costs and not included in this field. The amount entered in this field should be in **total dollars** and is not expressed as a cost per day. The totals should be the amount anticipated for the period covered by the current plan.
16	Waiver Cost/Day Total	The total cost of the ongoing **waiver-covered** services listed in Field 68 of the service plan. Do not include any start up, one-time or administrative costs that may be claimed by the agency during the current year or at the end of the year in this total.
17/ 18	HSRS code/Prior Living Arrangement-Name/Type	The type of residence in which the person resided immediately prior to their start in the Waiver.
19/ 20	HSRS code/Current Living Arrangement- Name/Type	The type of residence in which the person is expected to reside when he or she begins waiver services.
21	Waiver Agency (Waiver Contact)	The name of the county, tribal or contract agency currently responsible for managing the individual's waiver services. A change in this element requires the submission of a revised/updated service plan.
22	Agency Telephone No.	The phone number which the agency identifies as the primary number to use to contact agency staff/officials about this individual.

No.	Title	Description
23	Support & Service Coordinator/Care Manager Name	
24	Support & Service Coordinator/Care Manager Telephone numbers: Office and Cell	Include area code
25	Mailing Address (Agency)	Include zip code
26	Mailing Address of SSC/CM	Include zip code
27	E-mail address of Agency	
28	E-mail address of SSC/CM	
29	Name- Parent(s) or Guardian	If the participant is a minor, list the guardian if the guardian is different than the parent. If there is no guardian, list the parent. For adults, always list the guardian if there is a guardian or enter the word "self" if the person is his or her own guardian.
30	Telephone No. (Home)	Include area code
31	Telephone No. (Work)	Include area code
32	Mailing Address (Street/ PO Box)	
33	City	
34	State	
35	Zip Code	
36	E-mail address	
37	Telephone No. (Cell)	Include area code
	IN CASE OF EMERGENCY NOTIFY:	
38	Name	Name of the person designated as the waiver participant's emergency contact.
39	Telephone No. (Home)	(include area code)
40	Telephone No. (Work)	(include area code)
41	Address	
42	City	
43	State	
44	Zip	
45	Relationship	Word that best describes how the emergency contact is related (family, friend, family friend, neighbor, etc) to the participant.
62	Service/SPC Code number	The three or five digit SPC code assigned to the particular service listed in the plan using the HSRS codes. This code only applies to services that are covered by the waiver. Medicaid card (State Plan) services and informal supports do not have an HSRS SPC number.
63	Service/SPC Name/ Informal Supports	The name of the service being planned for the participant. Use the HSRS name or, if the service is not a waiver service, a name that describes the type of service planned. This field should also include all informal supports.
64	Outcome Number	From the DDE-445a (Field 5), enter the number of the individual outcome that this service is provided to meet.
65	Service Provider Name, Mailing address, Phone (Include E-mail address, Cell phone number, if known)	The individual/agency name of the service provider. Use the name that appears on any license or certification if any.
65A	Start Date	The date on which approved services are to begin. See Medicaid Waiver Manual for instructions on this definition. http://dhfs.wisconsin.gov/bdds/waivermanual/index.htm
65B	End Date	The date on which the identified services will stop (if applicable).

No.	Title	Description
66	Unit Cost and type ($/hour; day)	The cost per unit of service for the service provided. Consult HSRS (desk card or handbook) for the types of units assigned to each Waiver covered service. http://dhfs.wisconsin.gov/HSRS/index.htm For Medicaid card services, use the billing rate anticipated to be received.
67	Authorized Units of Service and Frequency (#/day, week or month)	The number of units of service the county authorizes for this participant during a specified period of time. (E.g., days per month authorized for adult family home).
68	Daily Cost	The total cost of the Waiver, Medicaid, COP or other program funded service, annualized, divided by 365 days.
69	Funding Source including cost share	Enter any of the funding sources listed here. If the funding source is not on the list, write in other and explain or list the source. **Includes:** Medicaid Card, BIW-state match, BIW-local match, CIP 1A-State, CIP 1A-Local, CIP 1B-State, CIP 1B-Local, CLTS-DD, CLTS-MH, CLTS-PD, COP-W/CIP II, COP, COR, Community Aids (CA), Cost share, participant funds (SSA, SSI, etc.) and local sources listed below. **NOTE:** Any funding source that includes the word **local** means there are county sources of funds that are being used to match the federal funds. After the word local, the specific source of the match must be identified. The following local sources of funds may be used for local match or may also fund services that are not covered by the waiver but are being provided and listed in the plan: Act 405, Family Support Program (FSP), CA, COP or County general fund revenues derived from such sources as local property tax and local sales tax.
70	Notifications	Summary of notifications: Right to choose waiver program/institutional services. Notification of participant rights and responsibilities. Notifications must be given to all applicants/participants verbally and in writing.
	Participant Signature	The Waiver program participant signature is **required** if participant is age 14 or over and the person is capable of signing the form.
	Date Signed	Date the plan was signed by the participant.
	Parent/Guardian/Authorized Representative Signature	
	Date	Date the plan was signed by the guardian or authorized representative.
	Witness Signature (identify)	
	Date	Date the plan was signed by the witness.
	Witness Signature (identify)	
	Date	Date the plan was signed by the witness.
	Support & Service Coordinator Care Manager Signature	
	Date	Date the plan was signed by the support and service coordinator/ care manager.